

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/16/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>MEMORIAL HOSPITAL OF SOUTH BEND</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 N MICHIGAN ST SOUTH BEND, IN 46601</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00120748</p> <p>Substantiated: No deficiencies cited.</p> <p>Date: 1/15-16/13</p> <p>Facility Number: 005053</p> <p>Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor</p> <p>Memorial Hospital of South Bend, Memorial Epworth Center Geropsych Institute is in compliance with 410 IAC 15-1.5-10, Utilization review and discharge planning services, 410 IAC 15-1.5-6, Nursing service, 410 IAC 15-1.5-5, Medical staff, and 410 IAC 15-1.6-5, Psychiatric services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 02/08/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1